JCIC Meeting Minutes
January 20, 2010 10:00 – Noon EST
Kentucky Department for Behavioral Health, Intellectual & Developmental Disabilities

Held as Video/Audio Conference Call

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Attending Representatives:

Regional MH/MR Boards

Four Rivers:	Brad Dossett
Pennyroyal:	John Pyle
River Valley:	Lisa Boehman-Kincheloe
	Talea Parker
Lifeskills:	Art Stockton
Communicare:	Vicky Heath
	Elaine South
	Sue Robinson
Seven Counties:	Gerald Brazeau
Northkey:	Gary Goetz
	Carolyn Earls
	Tanya Kaup
Comprehend:	Rick Jones
	Lonnie Foley
Pathways:	Tom Leach
Mountain:	Walter Owens
Kentucky River:	Darlene Dixon
Cumberland River	Miranda May
	Kim Stewart
Adanta:	Cathy VanBruggen
	Susan Wheeldon
	Beverly Loy
Bluegrass:	Tammy Nalle
	Nathan Millay

KDMHDDAS:

Mental Health / Substance Abuse:
- Lou Kurtz
- Janice Johnston
- Michele McCarthy
- Michele Niehaus

Mental Retardation:
- Kedra Fitzpatrick

Administration & Financial Management:
- Hope Barrett – Chairperson
- Teri Horn
- Susan Walker

Commissioner's Office:
- not attending

University of Kentucy:

Research and Data Management (RDMC):
- Harry Hughes
- Jeanne Clark

Center on Alcohol & Drug Research (CDAR):
- Erin Stephenson

KARP: Carl Boes

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Introductions - Welcome

1. Client/Event Data Set

1a. Service Utilization Report.

Previously: The Service Utilization Report is used internally to identify areas where service reporting may need improvement. This report reflects the basic information as reported from the Centers with removal of duplication of service event records and is considered foundational to quality improvement efforts at the Department.

Update: This report is available at each CMHC Regional Login Page under the "Reports (all regions)" drop-down listing.

Centers requested that the report include the ability to drill-down to a month's data. The report will be altered to include this addition and reposted when it is ready.

1b. Deaf and Hard of Hearing

Michele Niehaus (the Department's Adult Branch of Behavioral Health Division) presented proposed changes to the answer options for field #70 in the CMHC client data set. The purpose is that the DHH program reporting needs improvement. The group agreed upon the following adjustments to this field. **These will become effective with July 2010 data submission.** During the first year of collection (State Fiscal Year 2011), this will be only a Possible Error and will become a General Error in SFY2012.

Additionally, Michelle Niehaus will develop a training tool for aiding Centers in training their staff to correctly record this data field. This tool will be posted to each Center's Regional Login Page by March 1st.

Current Codes:

70. Deaf and Hard of Hearing

Valid Codes:	0	No
	1	Yes
	6	Not Applicable
	7	Unknown
	8	Not Collected

Recommended Changes:

70. Deaf or Hard of Hearing

Valid Codes	0	Hearing
	~~1~~	~~Yes~~
	2	Deaf
	3	Hard of Hearing
	4	Deaf-Blind
	6	Not Applicable
	7	Unknown
	8	Not Collected

Description:

Definitions are aimed at a person's functioning communication rather than medical status.

Hearing: A person whose hearing is within normal range and exhibits no functional limitations in communication due to hearing loss

Deaf: A person who, with or without amplification, cannot understand spoken language. S/he relies on visual means of communication and may use American Sign Language, another sign language, speech reading, or gestures to communicate.

Hard of Hearing: A person with a hearing loss, unilaterally or bilaterally, who, with or without amplification, can understand spoken language in some settings.

Deaf-Blind: A person with some degree of hearing loss **and** vision loss which affects his/her ability to access spoken language and written communication

For further support, Michelle offered the following responses to the group's questions:

"What is the purpose for the new level of detail?"

We currently group Deaf and Hard of Hearing, but an individual is one or the other. The accommodation needs are very different depending on how a person best communicates. By separating Deaf from Hard of Hearing then adding Deaf-Blind, we can get a sense of what types of supports our consumers may need to most benefit from treatment. That can help us in program planning, Technical Assistance and training to the clinicians, and allocating funds to cover the true needs of consumers.

"How is funding affected?"

Currently the Department has funds to reimburse CMHC's for mental health, addictions, or DDID services where interpreters are used. The funds for mental health are used each year (and often run out), but the other two "pots" are under-utilized. By getting a clearer picture of what the consumers need, we can re-allocate within Deaf and Hard of Hearing Services and/or develop programs and services for a wider range of accommodations and wraparound funds. In FY2011 that will include "Language Tutors / Communication Coaches" for the DDID population. In FY2010 we have piloted reimbursement for CMHC consumers using interpreters at AA or NA meetings.

Would this be an added burden to clinicians?

By knowing the communication needs of consumers from the start, effective strategies can be put in place that ease the burden on the clinician and the stress on the consumer. The DHHS staff will develop a short training tool on how to ask the questions and what to do when they are endorsed if more help is needed. In addition, individuals and CMHCs can request training and consultation.

1c. Collateral/Co-Dependency Affects on Treatment Episode Data Discharge NOMS

This field has significant impact on SA NOMS. CDAR would like to sample SA medical records (<10 per Center that volunteers) to better understand the client records and the collateral/co-dependency diagnostic criteria.

JCIC representatives are asked for feedback on how these data are recorded. We ask for a few Centers to voluntarily pilot with us on the record verification.

2. Human Resources Data Set

none

3. Division-Specific Topics:

3a. Mental Health / Substance Abuse (MH/SA)

- Substance Abuse: Self-Report of Attendance to self-help groups.

  As of July 2010, this data is required for only substance abuse clients. Since we've been preparing for this, RDMC will be able to accept submissions from Centers with the January 2010 Client and Discharge files. This new field will be the last item in the flat file submitted each month (following data field "military history"). While it will be optional for the centers prior to July 2010, it will be required on Substance Abuse Clients beginning with July 2010 files. During its first year of data collection (SFY2011) it will be a General Error.

3b. Mental Retardation (MR)

- MR Service Utilization.
  Report validation was requested May 2009. Any centers who under-report service code 91 (MR Crisis) are asked to work with your RDMC Regional liaison to improve accuracy of this service code. Additionally, Kedra (Division of Developmental & Intellectual Disabilities) can be contacted at Kedra.Fitzpatrick@ky.gov or (502)564-7700 with any questions. Specific attention should be paid to us of unrestricted MR crisis funds; all unrestricted MR crisis funds should be reported using only service codes 24, 25 or 91.

3c. Administration & Financial Management (A&FM)

none

4. New Item(s)s

There was concern that TEDS SA episodes are being under-reported for dually diagnosed clients because MH services are being ignored when RDMC creates the SA Treatment Episodes. TEDS episodes may be getting terminated prematurely due to gaps in SA services of greater than 30 days when MH services could be considered to be part of the treatment episode.

This discussion revisited the issue that dual diagnosed clients are not reported in the SA data. Previously (July 15, 2009), we reviewed a proposal from the Data Users Group which included an option of adding new Special Indicator codes. The number of new codes proposed at the time may have been overwhelming and the suggestion was not well-received.

Since further concern has been raised that we may not be getting credit for all the appropriate services for dually diagnosed clients, Harry suggested we revisit the issue. He thought we should consider 1) reinstituting the "Missed Appointment" service codes in the Event file or 2) use a simplified revision of Special Program Indicator codes to catch the dual diagnosed services.

Centers stated that by nature of the billing system, they do not provide a dual diagnosis service; they provide either a "MH" service or an "SA" service. It was suggested that dual diagnoses clients be selected using both 'markers' in the client file rather than seeking dual-diagnosis services in the events file. In response, the Department

commented that this method has proved insufficient since the SA clients are discharged after 30 days lapses without a documented SA service. In reality the client may be receiving MH services as part of a dually diagnosed treatment plan.

Questions were raised as to whether we could, for dually diagnosed clients, include the MH services as part of the SA episodes. Participants asked whether the current TEDS service criteria was dictated by SAMHSA or if it was self-imposed by the department.

Next Steps: answer the question about whether SAMHSA will allow our TEDS criteria to include MH services. Department staff and RDMC staff will look into this before the next meeting.

5. <u>Next Meeting</u> - March 17, 2010 - 10am-noon (*Eastern Standard Time*)

<u>SFY 2010</u>
- May 19, 2010

<u>SFY 2011</u>
- July 21, 2010
- September 15, 2010
- November 17, 2010
- January 19, 2011
- March 16, 2011
- May 18, 2011

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To Participate:

Via video-conference:

Meeting Room #: 1801364

Via tele-conference:

1. Dial (502) 875-9991 You will hear a voice prompt asking you to enter your conference ID followed by the # sign.
2. Enter "1801364#".
3. You will be automatically joined into the conference.

In Person:

The Department staff have reserved "Small Conference Room" located at 100 Fair Oaks Lane, 4th Floor, Frankfort, KY

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